ARKANSAS SPINAL CORD COMMISSION

SPINAL COURIER

Vol. 3 No. 2 January, 1992

WE'RE MOVING ON UP!

That's right, we're moving! We have outgrown our present office space and are moving to new quarters on February 1, 1992.

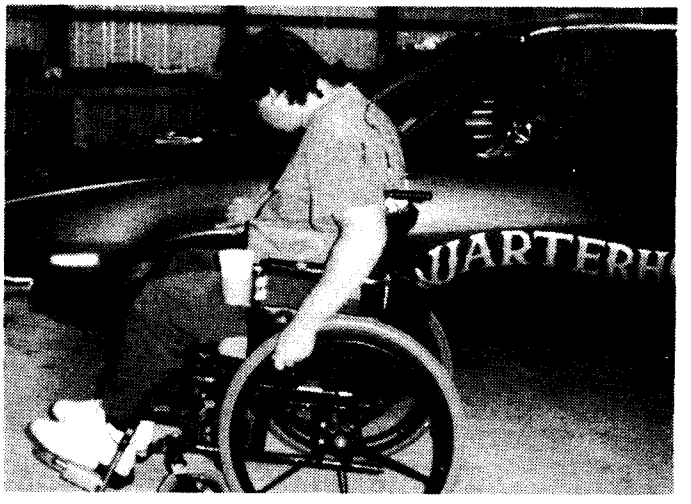
The new offices of the Arkansas State Spinal Cord Commission, Central Office and the Little Rock area Case Management Office will be located on the fourth floor of the Prospect Building in west Little Rock. Our new address after 2-1-92 will be:

ASSCC
1501 North University, Suite 470
Little Rock, AR 72207

The telephone numbers for both offices and the FAX number will remain the same.

Please make a note of the new address.

Look for our open house in March!



Douglas Blann - Race Car Driver

I was injured in a diving accident August 25, 1985. At the time, I was only 22 years old. I crushed my C-6 vertebrae and now remain paralyzed. My level of injury is C-5, C-6, but I have very good hands and strong triceps which is usually associated with a lower level injury. I have been fortunate enough to have regained some hand function which has al-

See Blann on page 8.

Save Money on Electric and Phone Bills

Low income Arkansans are eligible to take advantage of some excellent information provided by the Senior and Low Income Council on Communications and Energy (SLICCE). SLICCE is currently trying to sign up a record number of qualified persons for two benefits:

1) Any household with an annual income of $12,000 or less can have the sales tax waived on a portion of their electric bill. This can amount to a $5 to $8 reduction per month. For qualifying individuals the completion of one time sign up is all that is necessary. For an application form, contact your local electric company or your ASSCC Case Manager.

2) Link-Up America provides assistance to customers without telephone service by paying half the installation fee. Individuals who qualify are recipients of Food Stamps, Medicaid (Including Supplemental Security Income), Aid to Families with Dependent Children, Home Energy Assistance Program, or HUD housing assistance. A card must be completed, certified by the agency granting the benefits and returned to the telephone company.

For more information about the program and to receive a card to fill out for the telephone installation fee reduction, call toll-free 1-800-772-5767; in Little Rock call AP&L Customer Relations at 377-5767.

Both benefits are available through any electric and telephone company statewide so take a SLICCE out of your bills!

SPINAL COURIER

Published quarterly by
Arkansas State
Spinal Cord Commission

Cheryl L. Vines
Executive Director

Thomas L. Farley
Editor

Published in cooperation with the Paralyzed Veterans of America, Spinal Cord Injury Education and Training Foundation.

BUCKLE UP!

HAVE SLIDES, WILL TRAVEL

A new educational slide presentation, entitled "Traumatic Spinal Cord Injury in Arkansas" is now available for group presentation through the ASSCC's Injury Prevention Office. Designed to increase public awareness of the causes, consequences and prevention of spinal cord injuries, the slide show is based on an analysis of the Commission's surveillance data over the last ten years.

Each year over 65 Arkansans sustain spinal cord injuries from motor vehicle crashes, falls and diving into shallow water. Among the questions addressed are: What is a spinal cord injury and what are the results of injury? What are the leading causes of injury? Who is at highest risk? How can you prevent such injuries?

The slide presentation is available to community groups or organizations anywhere in the state interested in safety and injury prevention. Call Ann Whitehead, Commission Health Educator, at 324-9620 to schedule a presentation for your group today.

SPINAL COURIER Letters

Questions • Suggestions • Directions • Answers

Dear Editor:

Are there any horseback riding facilities in Arkansas for people with disabilities? My 13 year old has spinal bifida and is very eager to try it since most of her friends ride on a regular basis. Our doctor said that with the proper equipment, there shouldn't be any problems.

Unsigned

Readers, can you help me out with this one? It's been a long time since I was on a horse!

Dear Tom:

Mr. William Newbern is a client of mine who may be the oldest post spinal cord injury ASSCC client in the state. He is certainly the oldest post SCI in my service area. I have a photo of Mr. Newbern along with some interesting facts about his life if you would like to use this story in the Spinal Courier.

Trena Hyde
ASSCC Case Manager

Well, let's see now, Mr. Newbern was injured on November 20, 1949 and this is January, 1992 . . . Boy this guy is old! Mr. Newbern has been injured more than 42 years! Sounds like he has taken care of himself and is still on the go.

How about it readers? Is there anyone out there who was injured before 11-20-49? Is Mr. Newbern the oldest post SCI in the state? Tell you what - anyone who has been injured more than 40 years, send me a photo and a note about yourself. I'll put them all, including William Newbern, in an upcoming issue of the Spinal Courier.

Erma Bombeck's Top Ten

This is the day when all the list-makers come out of the woodwork. The day when columnists look either backward or forward to list their top 10: The 10 best dressed, the 10 greatest moments in sports, the 10 top headlines, the 10 most outrageous quotes, the 10 biggest disasters, the 10 top movies, the 10 best-selling novels, and the 10 biggest hits. Today, I would like to offer my nomination for the most admired list.

My nominee is without age or any particular sex.

He lives in a hospital bed, a wheelchair, a rest home, at home, in a world of darkness, or a prison of silence.

His job? Survival. His challenge? Live with disease and pain. His goal? Every day when God opens up a new day for business, he shows up for it.

My nominee never looks back. It's too painful. He never looks forward. It's a luxury. He lives for what he has this day.

My nominee exists on a diet of optimism and hope. Occasionally he falls off the emotional diet and pigs out on self-pity, but returns again to battle.

My most admired entry makes those around him comfortable and goes out of his way to help us deal with problems.

He allows us to see in him that nothing is as important as today and nothing as uncertain as tomorrow.

He offers to us a legacy of courage that will sustain us for years to come.

Reprinted from Erma Bombeck's column At Wit's End, published in the Arkansas Gazette.

Implementing the Americans with Disabilities Act

The Americans with Disabilities Act of 1990 (ADA), Public Law 101-336, gives civil rights protections to individuals with disabilities that are like those provided to individuals on the basis of race, sex, national origin, and religion. It guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, state and local government services, and telecommunications. The ADA was signed into law on July 26, 1990 by President Bush.

EMPLOYMENT

- Employers may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job.
- Employers can ask about one's ability to perform a job, but not inquire if someone has a disability or subject a person to tests that tend to screen out people with disabilities.
- Employers will need to provide "reasonable accommodation" to individuals with disabilities. This includes steps such as job restructuring and modification of equipment.
- Employers do not need to provide accommodations that impose an "undue hardship" on business operations.

Who needs to comply:

- All employers with 25 or more employees must comply, effective July 26, 1992.
- All employers with 15-24 employees must comply, effective July 26, 1994.

TRANSPORTATION

- New public transit buses ordered after August 26, 1990, must be accessible to individuals with disabilities.
- Transit authorities must provide comparable paratransit or other special transportation services to individuals with disabilities who cannot use fixed route bus service, unless an undue burden would result.
- Existing rail systems must have one accessible car per train by July 26, 1995.
- New rail cars ordered after August 26, 1990 must be accessible.
- New bus and train stations must be accessible.
- Key stations in rapid, light, and commuter rail systems must be made accessible by July 26, 1993, with extensions up to 20 years for commuter rail (30 years for rapid and light rail).
- All existing Amtrak stations must be accessible by July 26, 2010.

PUBLIC ACCOMMODATIONS

- Private entities such as restaurants, hotels, and retail stores may not discriminate against individuals with disabilities, effective January 26, 1992.
- Auxiliary aids and services must be provided to individuals with vision or hearing impairments or other individuals with disabilities, unless an undue burden would result.
- Physical barriers in existing facilities must be removed, if removal is readily achievable. If not, alternative methods of providing the services must be offered, if they are readily achievable.
- All new construction and alterations of facilities must be accessible.

STATE AND LOCAL GOVERNMENT

- State and local governments may not discriminate against qualified individuals with disabilities.
- All government facilities, services, and communications must be accessible consistent with the requirements of Section 504 of the Rehabilitation Act of 1973.

TELECOMMUNICATIONS

- Companies offering telephone service to the general public must offer telephone relay services to individuals who use telecommunication devices for the deaf(TDDs) or similar devices, effective July 26, 1993.

WHAT YOU CAN DO

The ADA applies to all individuals, organizations, businesses and agencies in Arkansas. Most people are aware of it, but some are not, or will choose to be "slow" in complying. If a store, theater, school or other public facility is not accessible to you, tell them that it is now a federal law. Suggest what they need to do to make it accessible. Unfortunately, there are no agencies whose responsibility it will be to monitor compliance. The Department of Justice, EEOC and Department of Transportation are preparing the regulations. If you are unsuccessful in getting an agency or facility to meet the regulations, your recourse will be to file a lawsuit.

For more information on the ADA in Arkansas, contact:
Mainstream Living 371-0012
Arkansas Disability Coalition 221-1330
Advocacy Services, Inc. 324-9215

Results of the Pressure Sore Prevention Research Grant - A Summary

In 1988 the ASSCC received a three year research grant from the Centers for Disease Control, to study pressure sores in individuals with SCI. Over 350 ASSCC clients participated in this study. An overview of the major findings follows:

Introduction Decubitus ulcers, commonly known as pressure sores are the most prevalent, costly and preventable secondary condition resulting from spinal cord injuries. Pressure on subcutaneous tissue results in damage and death of the tissue cells causing sores which vary in severity from a red spot on the skin to gaping open, necrotic wounds and sometimes death of the individual. The lack of sensation in people with SCI often results in lack of awareness of damaging pressure. A statewide survey of Arkansans with spinal cord injuries in 1990 reflected that 18% had a pressure sore at the time they were surveyed and 26% had been hospitalized at some time due to a pressure sore.

The Spinal Cord Commission, through this Demonstration/ Epidemiology Project set out to document the incidence of pressure sores and to implement strategies to reduce the incidence.

Description Two major components of the project were developed. The retrospective component or survey, included documenting incidence and cost. The prospective component included interventions to reduce incidence through identification of clients at risk, inhome education, community education and psychosocial intervention. Each component of the project is described below.

Spinal Cord Injured Individuals and Pressure Sores A survey was conducted in an eleven county area of individuals with traumatic spinal cord injuries who were over the age of eleven. Three hundred twelve individuals participated in the survey which was conducted by telephone or in person (if no phone). Demographic information, a description of functional level of SCI, incidence of pressure sores as well as information related to self care, therapeutic equipment use, personal habits, medical complications and daily activities was collected. Clients who stated that they had a pressure sore at the time of the survey (21%) or that they had had a pressure sore in the past (66%) were asked to participate in an intervention program. Preliminary or "soft" refusals were followed up by case managers to reinforce involvement. Those responding yes to hospitalization for pressure sores (16%) were asked to participate in the hospital cost study.

Results of the survey reflected no significant differences in age at onset, sex, personal habits, or use of alcohol or medications between those who sustained pressure sores and those who did not. Race was a correlate with severity of pressure sores, as dark skin is considered a risk factor. Survey analysis indicates that most individuals react to pressure sores rather than taking measures to prevent them.

Hospital Cost Study Medical records of 45 persons with SCI who had been hospitalized for pressure sores within the past 10 years were reviewed to obtain hospital costs. Cost data was obtained on 39 cases. Analysis reflected that these 39 individuals had 103 hospitalizations during the study period. The mean number of hospitalizations was 2.6 but the frequency varied from 1-9. For the purpose of this study cost was defined as institutional costs during acute and rehabilitation hospitalizations. Physician costs (surgeon, anesthesiologist etc.) are not obtained. The average hospital stay was 39.5 days and rehabilitation stay 20.8 days. Average total cost was $92,723. Medicaid and Medicare reimbursement information was obtained on 25 of the individuals and Medicaid paid about 90% of Medicare allowable cost for acute and rehabilitation hospitalizations.

Total annual hospitalization costs for treatment of pressure sores in individuals with spinal cord injuries in Arkansas is $1.15 million.

Identification of High Risk Individuals Many individuals who are at risk for pressure sores due to chronic incidence or new injuries are not identified in time to prevent future problems or provide intervention. The project Liaison Case Manager maintained regular contact with 14 major acute hospitals and 2 rehabilitation centers in the project area to identify spinal cord injury admissions and discharges. She interviewed new referrals, maintained weekly contact with individuals during hospitalizations, attended staffings, alerted project supervisor to discharge plans and facilitated entry into inhome education program. Fifty nine new injuries were identified by this program during the 18 months of the project and 26 were referred to the Inhome Prevention Program. This program has been assumed by the Case Managers of ASSCC.

In-home Education Program The primary prevention intervention was the inhome education program. Individuals were referred to the program through the liaison or field case manager or by survey responses. Specially trained home health nurses provided pressure sore prevention education to individuals and their families and care providers in the home environment. Clients were seen weekly for four weeks to carry out the educational sessions including instruction in skin inspection, hygiene, etiology and common sites of pressure sores, problem solving

See Results on page 5.

Results from page 4.
skills and prevention strategies. Follow-up was provided monthly for three months and again at six months for final evaluation. This reinforcement of positive behavior and facilitation of selfcare allowed the individual to take responsibility for maintaining health and skin integrity. Nursing assessments were recorded at each visit and were analyzed at the completion of the project.

A decrease in the incidence and severity of pressure sores was noted. 42% of the participants had at least 1 pressure sore on initial assessment. On final evaluation 19% had at least one pressure sore. Number of pressure sores also decreased. Risk factors were at least 2 in most participants. This individualized, inhome prevention education allowed the training to be individually paced and addressed the needs and problems hands on during "real life" experience of the home. It also required the participant to take responsibility for own prevention program rather than delegating it to someone else or ignoring it.

Psychosocial Intervention The literature and experience agree that there appears to be a psychosocial component in the incidence of chronic pressure sores in individuals with spinal cord injuries. This study consisted of two parts, a comparison of personality variables between individuals with chronic pressure sore and individuals without chronic pressure sores and the impact of a psychological intervention with individuals with chronic pressure sores. Three personality measures, the Sense of Coherence Questionnaire, Interpersonal Dependency Inventory and Rosenberg Self Esteem Inventory were administered to a matched control group of non-chronic (<1 incident in last 5 years) and test group of chronic (> 1 incident in last 3 years) individuals initially. Clients in the chronic group participated in eight weekly group sessions exploring issues of self-care, control and personal responsibility. The Rosenberg Self Esteem Inventory was administered again to both groups at the completion of the eight weeks. The chronic group scored higher on all measures of Sense of Coherence typically reflecting effective coping skills, though this group in fact demonstrates less effective abilities to cope. It is possible this reflects on unrealistic assessment of life experience and effective coping. As would be expected, the chronic group scored higher on interpersonal dependency. Significantly higher scores were noted in assertion of autonomy, indicating a value of autonomy and assertion of independence. Finally, both groups showed increase in self esteem on the post test. The chronic group who had participated in group therapy showed a significant increase.

Community Education Of individuals in our survey who had ever sustained a pressure sore (66%), 40% stated that they developed the pressure sore during a hospitalization, 64% of those during the first six months after injury. Often these occur before the individual with a spinal cord injury has any understanding or has received any education about pressure sores. Since Arkansas does not have a trauma plan nor an established continuum of care for spinal cord injuries, many healthcare providers are unfamiliar with pressure sore prevention. In addition, in Arkansas, many individuals do not receive rehabilitation care and are unaware of any secondary conditions or prevention strategies.

A health provider training program, covering similar components to the inhome education program was developed and provided by specially trained project nurses in acute hospitals, rehabilitation centers and nursing homes in the project area. Pre and post tests on knowledge of causes and prevention of pressure sores were administered to the participants. All participants improved in knowledge on the post test. Concepts that showed greatest improvements were 1) the need to eliminate pressure as a cause, 2) individuals with spinal cord injuries are at risk for pressure sores for the rest of their lives, 3) pressure sores can be prevented in long term care.

Pressure sore prevention protocols were developed based on the in-home and community education project results. These will be disseminated and utilized for future pressure sore prevention training with health care professionals.

Finally, two educational conferences, "Living With Spinal Cord Injuries in the 90's" for individuals with spinal cord injuries, their families and care providers and health care professionals were held. In addition to sessions on pressure sore prevention and care, other sessions addressed issues such as assertiveness, technology, equipment pain management, recreation, employment and sexuality and to promote independence and responsibility.

Conclusion Pressure sores are one of the most prevalent, costly and debilitating secondary conditions that plague individuals with spinal cord injuries. The majority of individuals with spinal cord injuries sustain a pressure sore at some time. Most pressure sores are preventable. Early identification facilitates improved care and intervention. Inhome prevention education resulted in a decrease in incidence and severity of pressure sores. An individual's personality including level of self esteem and interpersonal dependence may be a predictor for pressure sore incidence. Prevention education is also needed by health care professionals who care for individuals with spinal cord injuries in acute, rehabilitation and long term care settings. A continuum of prevention education and secondary condition care is needed to meet the lifelong needs of individuals with spinal cord injuries.

SPASTICITY

by
Shirley McCluer, M.D.
ASSCC Medical Director

Definition Spasticity is defined as a state of increased muscular tone with exaggerated tendon reflexes. It can occur in spinal cord injuries that are complete or incomplete, in fact, it is frequently more severe with incomplete injuries.

Clinical Variations Spasticity can vary from a minor nuisance to a completely disabling condition with severe contractures. It is not known why it is so much worse in some patients than others. Even patients who have almost complete recovery from their paralysis may still have a significant problem with spasticity. However, for most individuals it is mild to moderate in severity.

Immediately after a spinal cord injury, there is a complete loss of all reflexes below the injury (known as spinal shock). After 3-4 weeks (sooner with incomplete injuries) there is a gradual return of reflexes and tone in the undamaged nerves below the site of the injury. There will be a gradual increase in spasticity until it stabilizes at a level that will be "normal" for that individual. This may take up to 5-6 months.

After this stable level is reached, any sudden change in the severity of the spasticity may be the first sign that something is wrong. It is a non-specific sign (like fever) and doesn't indicate where the problem is. Possibilities are: pressure sores, bladder or kidney stones, fracture, or syringomyelia (cyst formation in the spinal cord). A careful medical evaluation is indicated to identify and eliminate such problems.

Spasticity is not always harmful. A moderate amount can be very useful and many individuals learn to "trigger" specific spastic movements to help with self care activities such as transfers or dressing. It also helps to prevent atrophy (or shrinking) of the paralyzed muscles.

Management The perfect medication would be one that could decrease the spasticity in a predictable, controllable way (so that only the negative aspects would be eliminated and the positive aspects retained) with no side effects from long time usage (since the problem is likely to be a permanent one and whatever treatment is used will not be short term). Unfortunately such an ideal does not exist and medication should be used only after other measures have been tried and the spasticity is severe enough to significantly interfere with self care activities.

Physical Measures The following general factors should be considered before using medication:
1. Eliminate medical problems - Since medical complications will increase spasticity, good care to prevent complications or treat them early will help.
2. Range of motion exercises done regularly to prevent contractures or stretching to correct contractures if they occur. Self care activities such as dressing oneself can be a good form of range of motion exercise. Sleeping in the facelying position is also helpful.
3. Standing for an hour on a regular basis will often reduce spasticity for several hours afterward. This can be done with braces or in a standing frame.
4. Activity - The more active a person is the less likely they are to have severe spasticity.

Medications Valium (Diazepam)- When Valium was released in the 1960's it was the first "muscle relaxant" that had a significant effect on spasticity. For many years SCI physicians (including me) started most of our patients on Valium despite the increasing publicity about its side effects of addiction and interference with the ability to think and concentrate. However, I am now firmly convinced that the disadvantages of Valium far outweigh its advantages. I strongly encourage physicians NOT to start patients on Valium and I strongly encourage patients who are already on it to make every effort to wean themselves off of Valium as soon as possible!

Surprisingly, most patients who quit Valium after several years have found that initially there is an increase in spasticity, but within 4-6 weeks after stopping, the spasticity is not significantly worse than when taking Valium. In addition, they are amazed at the change in their personality and their improved ability to learn and concentrate.

Lioresal (Baclofen) - This is currently the drug of choice, but it leaves much to be desired. Its disadvantages are that the dosage must be started low and gradually increased over 3-4 weeks before reaching the usual therapeutic dosage of 20mg 4x/day. The effect only lasts a short time so it must be taken more frequently (i.e. 4x/day). Serious complications have been reported when stopping abruptly. It should always be tapered off gradually. It is expensive.

Dantrium (Dantrolene) - Although effective in some types of spasticity (M.S., cerebral palsy, and stroke), it is usually less effective in spinal cord injury. In addition there are potential side effects (liver damage) which make it more dangerous. Anyone with SCI who is taking Dantrium should be very sure that it is really helping enough to justify the risks.

Other medications are sometimes effective in some individuals. This includes Clonidine which can be taken by mouth or used as a skin patch.

Summary

- Spasticity can be a major problem in a small percent of cases, but is usually more of a moderate annoyance. There are no good medications to treat it.
- Medications should not be used for spasticity unless it is severe enough to significantly interfere with functional activities.
- If the spasticity is just as bad on medication as without it then DON'T TAKE THE MEDICATION! Why take chances with later complications from the medication if it isn't helping?
- Anyone who is still taking Valium should try to discontinue it.
- Anyone who has been on the same medications or the same dosage for several years should periodically try to lower the dosage or discontinue all medications completely to be sure it is actually helping.
- Anyone taking more than one medication for spasticity should try to eliminate as many as possible - but do it gradually!

In the next Newsletter I will discuss surgical options for severe disabling spasticity.

ARKANSAS OUTDOORSMEN UPDATE

by

Gary Turner

Arkansas Disabled Outdoors is now Arkansas Outdoorsmen with Disabilities. We decided to put the person before the disability! Our new post office box is P.O. 248, Calico Rock, AR 72519.

Our Vice President, Jim Hammett is in the process of filing our non profit status with the state of Arkansas and the IRS.

Members, Sloan Lessley and Gary Turner, attended the Project Access conference at Easter Seals Alabama Special Camp for Children and Adults (ASCCA) in December. The conference was a huge success with over 100 people from 17 states and 53 agencies all working toward improving outdoor recreation for the disabled. We have videos and other material coming which will be interesting to all disabled hunters and fishermen but especially to high level quads.

We are working to organize all of the information about Camp ASCCA, the adaptive hunting and fishing equipment from Shepard Spinal Center and the activities we are trying to start here in Arkansas into a program for presentation to groups and Rehab hospitals here in Arkansas.

I might mention here that all the travel, telephone, mailing cost and all other expenses are coming out of the pockets of the officers of Arkansas Outdoorsmen. We are not funded by any local, state, federal or private organization. We are trying to get this going as fast as we can, so please be patient; we'll get to you.

In the meantime, write us at P.O. Box 248, Calico Rock, AR 72519 or call Gary Turner at 297-8053 (Calico Rock) or Jim Hammett at 9851930 (Jacksonville).

Rollin' Razorbacks 1992 Schedule

The Rollin Razorbacks enter 1992 with a record of eight wins and one loss, rated #1 in the nation. Come out and see them play! All home games are played at Sylvan Hills High School in Sherwood.

Date	Event	Where
Jan. 4-5	Worthen National Bank Classic	HOME
Jan. 11-12	Music City Invitational	Nashville, TN
Jan. 24-26	Bluegrass Invitational	Lexington, KY
Feb. 1-2	US Pizza/Coors Light/ Quickie Invitational	HOME
Feb. 14-16	Pioneer Classic	Birmingham, AL
Feb. 22-23	Regional Playoffs	St. Louis, MO
March 7-8	Sectional Playoffs	HOME
March 20-21	FINAL FOUR	Albuquerque, NM

Blann from page 1.

lowed me to be more independent. Moreover, it enables me to participated in things like drag racing.

I own a 1973 Ford Pinto that is powered by a 289 with C-4 transmission and 9-inch rear-end. I race in the Pro Class with times consistently in the 10:80's. The car is equipped with hand controls for the throttle and brake. I can shift manually taking my hand off the steering wheel each time. I've been driving for about 3 years, but can only race through the first half of the season due to the extreme heat that occurs during the latter half of the season. Other "Quads" who can't sweat will know what I'm talking about. I've never won a major race; but, I've won about ten minor ones. To be sure, that is an accomplishment in itself.

I currently attend Southern Arkansas University Tech in Camden, Arkansas and am studying Computer Science. This is my Sophomore year and I currently have a 3.75 grade point average. My activities at school include being President of Phi Theta Kappa, a national honors fraternity. In addition, I received the honor of being voted into Who's Who in American Junior Colleges this year. I have also won awards for having been on the Chancellor's List (4.0 GPA), Dean's List (3.5 GPA), and one for being a member of Phi Theta Kappa. Furthermore, I tutor College Algebra when not in class. As you can see, I am a very busy person at school!

LTAC Fact Sheet Available

A new fact sheet on Long Term Attendant Care is now available from the ASSCC. Single copies of the fact sheet is free and is available from the Education and Resource Center or from any ASSCC Case Manager.

Fact sheets are one page information pamphlets about specific spinal cord disability problems. The LTAC fact sheet is the seventh in the ASSCC fact sheet series.

Education and Resource Center Open during Move

The ASSCC's upcoming move has delayed the "official" opening of the Education and Resource Center until March, 1992. Nevertheless, resources can still be borrowed from the Center now.

To place your information request, call or write Loretta Decker at ASSCC, 1501 North University, Suite 400, Little Rock, AR 72207 or call 324-9620. Loretta will process and mail your request as soon as possible.

The Education and Resource Center is funded by the Paralyzed Veterans of America and provides information and resources to Arkansans with spinal cord injuries and health care professionals.

Call for Conference Program Ideas

The 3rd annual Spinal Cord Commission Conference will be held June 5, 1992. The exact time and location (in the Little Rock area) are being finalized. We are presently requesting input and suggestions from our Spinal Courier readers on topics, presentations and speakers for the conference. If you have a question or interest that you'd like to have addressed at the conference or if you know of a dynamic speaker (perhaps yourself) who could make a presentation on an SCI related topic, please send them in! We'll finalize the program in early March, so, please send your ideas today to: Conference Program Committee, ASSCC, 1501 North University Suite 470, Little Rock, AR 72207.

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